

AMENDED IN ASSEMBLY JUNE 29, 2004

AMENDED IN ASSEMBLY JUNE 16, 2004

AMENDED IN ASSEMBLY JUNE 26, 2003

AMENDED IN SENATE JUNE 3, 2003

AMENDED IN SENATE MAY 14, 2003

AMENDED IN SENATE APRIL 21, 2003

SENATE BILL

No. 921

Introduced by Senator Kuehl

(Principal coauthor: Assembly Member Goldberg)

**(Coauthors: Senators Alarcon, Cedillo, Florez, Perata, Romero,
and Soto)**

(Coauthors: Assembly Members Berg, Chan, Diaz, Hancock, Koretz,
Laird, Leno, Levine, Lieber, Longville, Lowenthal, Montanez,
Pavley, Ridley-Thomas, *Salinas*, Steinberg, Wiggins, and Yee)

February 21, 2003

An act to add Division 112 (commencing with Section 140000) to the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 921, as amended, Kuehl. Single payer health care coverage.

Existing law does not provide a system of universal health care coverage for California residents. Existing law provides for the creation of various programs to provide health care services to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program

administered by the State Department of Health Services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance.

This bill would establish the California Health Care System to be administered by the newly created California Health Care Agency under the control of an elected Health Care Commissioner. The bill would make all California residents eligible for specified health care benefits under the California Health Care System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. The bill would prohibit deductibles or copayments during the initial first 2 years of operation of the health care system, but would authorize the commissioner to establish deductibles and copayments thereafter. The bill would require the health care system to be operational by January 1, 2006, and would enact various transition provisions. The bill would require the commissioner to seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the California Health Care System, which would then assume responsibility for all benefits and services previously paid for with those funds.

The bill would create a Health Policy Board to establish policy on medical issues and various other matters relating to the health care system. The bill would create the Office of Consumer Advocacy within the agency to represent the interests of health care consumers relative to the health care system. The bill would create within the agency the Office of Health Care Planning, to plan for the health care needs of the population, and the Office of Health Care Quality, headed by the chief medical officer, to support the delivery of high quality care and promote provider and patient satisfaction. The bill would create the Office of Inspector General for the California Health Care System within the Attorney General's office, which would have various oversight powers. The bill would extend the application of certain insurance fraud laws to providers of services and products under the health care system, thereby imposing a state-mandated local program by revising the definition of a crime. The bill would enact other related provisions relative to budgeting, federal preemption, subrogation, collective bargaining agreements, and associated matters.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state.



Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Division 112 (commencing with Section 140000) is added to the Health and Safety Code, to read:

DIVISION 112. CALIFORNIA HEALTH CARE SYSTEM

CHAPTER 1. GENERAL PROVISIONS

140000. There is hereby established in state government the California Health Care System, which shall be administered by the California Health Care Agency, an independent agency under the control of the Health Care Commissioner.

140001. This division shall be known as and may be cited as the Health Care for All Californians Act.

140002. This division shall be liberally construed to accomplish its purposes.

140003. The California Health Care Agency is hereby designated as the single state agency with full power to supervise every phase of the administration of the California Health Care System and to receive grants-in-aid made by the United States government or by the state in order to secure full compliance with the applicable provisions of state and federal law.

140004. The California Health Care Agency shall be comprised of the following entities:

(a) The Health Policy Board.

(b) The Office of Consumer Advocacy.

(c) The Office of Health Care Planning.

(d) The Office of Health Care Quality.

(e) The Health Care Fund.

140005. The Legislature finds and declares all of the following:

1 (a) More than 6 million Californians lacked health insurance
2 coverage at some time in 2003 and 3.6 million had no health
3 insurance coverage at any time.

4 (b) Since 2001, the number of uninsured Californians has risen
5 significantly.

6 (c) More than 10 million Californians have no coverage for
7 prescription drugs. Millions of Californians lacking prescription
8 drug coverage are otherwise insured.

9 (d) Efforts to control health care costs and growth of health care
10 spending have been unsuccessful.

11 (e) Employers, retirement funds, and unions that offer and
12 negotiate for health insurance and benefits and individuals who
13 purchase health insurance are experiencing substantial increases in
14 health care costs and decreases in health care benefits.

15 (f) Unstable and unaffordable rate increases have caused
16 significant economic hardship for California residents and their
17 employers.

18 (g) One in two personal bankruptcies in the United States are
19 the result of health care costs.

20 (h) California does not perform well on standard health
21 outcome measurements.

22 (i) Unacceptable health access disparities exist by region,
23 ethnicity, income, and gender.

24 (j) Eleven of California's rural counties have no health
25 maintenance organizations that provide coverage to the county on
26 a countywide basis and 21 rural counties no longer have a
27 Medicare+Choice HMO.

28 (k) More than 80 percent of all Medi-Cal and uninsured patient
29 visits to emergency facilities are for conditions that could have
30 been treated in a nonemergency setting.

31 (l) Emergency departments and trauma centers face growing
32 financial losses.

33 (m) Advances in medical technology are not available to all
34 Californians who need them.

35 (n) Health care providers express significant professional
36 dissatisfaction with the current health care systems, as do health
37 care consumers.

38 (o) The California Medical Association found in 2001 that, in
39 California, uncompensated health care totaled five hundred forty
40 million dollars (\$540,000,000). Uncompensated health care has



1 caused 60 emergency departments (15 percent of the departments
2 in the state) to close since 1990.

3 (p) The California Medical Association found in January of
4 2001 that increasing patient volume and a decline in the number
5 of emergency rooms have made multiple hour waits for emergency
6 care the norm, and that ambulance diversion is becoming a
7 common method of dealing with emergency department
8 overcrowding. These developments pose significant dangers for
9 both insured and uninsured Californians.

10 (q) A quantitative analysis performed in 2002 by the
11 independent economic consulting firm, Lewin Inc., indicated that
12 under a single payer health insurance system, California could
13 afford to cover all California residents at no new cost to the state.

14 (r) According to the same report and numerous other studies,
15 by simplifying administration, achieving bulk purchase discounts
16 on pharmaceuticals, and reducing the use of emergency facilities
17 for primary care, California could divert billions of dollars toward
18 providing direct health care and improved quality and access.

19 140006. This division shall have all of the following
20 purposes:

21 (a) To provide universal and affordable health care coverage
22 for all California residents.

23 (b) To provide California residents with an extensive benefit
24 package.

25 (c) To control health care costs and the growth of health care
26 spending.

27 (d) To achieve measurable improvement in health care
28 outcomes.

29 (e) To prevent disease and disability and to maintain or improve
30 health and functionality.

31 (f) To increase health care provider, consumer, employee, and
32 employer satisfaction with the health care system.

33 (g) To implement policies, that strengthen and improve
34 culturally and linguistically sensitive care.

35 (h) To develop an integrated population-based health care
36 database to support health care planning.

37 140007. As used in this division, the following terms have the
38 following meanings:

39 (a) “Agency” means the California Health Care Agency.

(b) “Clinic” means an organized outpatient health facility that provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients who remain less than 24 hours, and that may also provide diagnostic or therapeutic services to patients in the home as an incident to care provided at the clinic facility, and includes those facilities defined under Sections 1200 and 1200.1 of the Health and Safety Code.

(c) “Commissioner” means the Health Care Commissioner.

(d) “Direct care provider” means any licensed health care professional that provides health care services through direct contact with the patient, either in person or using approved telemedicine modalities as identified in Section 2290.5 of the Business and Profession Code.

(e) “Essential community provider” means an integrated health facility that has served as part of the state’s health care safety net for low income and traditionally underserved populations in California and that is one of the following:

(1) A “community clinic” as defined under subparagraph (A) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code.

(2) A “free clinic” as defined under subparagraph (B) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code.

(3) A “federally qualified health center” as defined under Section ~~1395x(aa)(4)~~ 1396d(l)(2) of Title 42 of the United States Code.

(4) A “rural health clinic” as defined under Section ~~1395x(aa)(2)~~ 1396d(l)(1) of Title 42 of the United States Code.

(5) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 1603 of Title 25 of the United States Code.

(6) *Any clinic exempt from licensure under subdivision (h) of Section 1206.*

(7) Any other clinic deemed by the commissioner and Health Policy Board to meet specified criteria conferring essential community provider status.

(f) “Health care provider” means any professional person, medical group, independent practice association, organization, health facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

(g) “Health facility” means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, and includes those facilities defined under Section 15432(b) of the California Government Code.

(h) “Hospital” means all health facilities to which persons may be admitted for a 24-hour stay or longer, as defined in Section 1250 of the Health and Safety Code, with the exception of nursing, skilled nursing, intermediate care, and congregate living health facilities.

(i) “Integrated health care delivery system” means a provider organization that meets all of the following criteria:

(1) Is fully integrated operationally and clinically to provide a broad range of health-care services, including preventative care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services.

(2) Is compensated using capitation or facility budgets, except for copayments, for the provision of health care services.

(3) Provides health care services primarily directly through direct care providers who are either employees or partners of the organization, or through arrangements with direct care providers or one or more groups of physicians, organized on a group practice or individual practice basis.

(j) “Large employer” means a person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at *least* 50 percent of its working days during the preceding calendar year employed at least 50 employees, or, if the employer was not in business during any part of the preceding calendar year, employed at least 50 employees on at least 50 percent of its working days during the preceding calendar quarter.

(k) “Primary care provider” means a direct care provider that is a family physician, internist, pediatrician, an obstetrician/gynecologist, or a family nurse practitioner or physician assistant practicing under supervision as defined in California codes.

(l) “Small employer” means a person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service and that, on at least 50 percent of its working days during the preceding calendar year employed at least two but no more than 49 employees, or, if the employer was not in business during any part of the preceding calendar year, employed at least two but no more than 40 eligible employees on at least 50 percent of its working days during the preceding calendar quarter.

(m) “System” or “health care system” means the California Health Care System.

140008. The definitions contained in Section 140007 shall govern the construction of this division, unless the context requires otherwise.

CHAPTER 2. GOVERNANCE

140100. (a) The commissioner shall be the chief officer of the agency and shall administer all aspects of the agency.

(b) Except as provided in subdivision (d), the commissioner shall be elected by the people in the same time, place, and manner as the Governor, and shall serve a term of four years.

(c) Should a vacancy occur during the term of office, legislative confirmation shall be required for the position of the commissioner in the same manner and procedure as that required by Section 5 of Article V of the California Constitution.

(d) The first commissioner shall be appointed by the Governor not less than 75 and no more than 100 days following the operative date of this division, and shall be subject to confirmation by the Senate within 30 days of nomination. If the Senate does not take up the nomination within 30 days of nomination, the nominee shall be considered to have been confirmed and may take office.

(e) Should the Senate, by a vote, fail to confirm the nominee, the Governor shall appoint a new nominee, subject to the confirmation of the Senate as provided in subdivision (d).

(f) If the commissioner is at any time unable to perform the duties of the office, a deputy health commissioner shall perform those duties for a period of up to 90 days.

(g) In the event of a vacancy, or inability of the commissioner to perform the duties of office for a period of more than 90 days,

1 an acting commissioner shall be appointed by the Governor and
2 confirmed by the Senate for the balance of the commissioner's
3 term pursuant to the same process provided in subdivision (d).

4 (h) The commissioner is subject to impeachment pursuant to
5 Section 18 of Article IV of the California Constitution.

6 (i) The compensation and benefits of the commissioner shall be
7 determined pursuant to the same process as that provided in
8 Section 8 of Article III of the California Constitution.

9 (j) The commissioner shall be subject to Title 9 (commencing
10 with Section 81000) of the Government Code.

11 140101. (a) The commissioner shall be responsible for the
12 performance of all duties, the exercise of all powers and
13 jurisdiction, and the assumption and discharge of all
14 responsibilities vested by law in the agency. The commissioner
15 shall perform all duties imposed upon him or her by this division
16 and other laws related to health care, and shall enforce the
17 execution of those provisions and laws to promote their underlying
18 aims and purposes. These broad powers include, but are not
19 limited to, the power to set rates and to promulgate generally
20 binding regulations concerning any and all matters relating to the
21 implementation of this division and its purposes.

22 (b) The commissioner shall appoint the deputy health
23 commissioner, the Director of the Health Care Fund, the consumer
24 advocate, the chief medical officer, and the Director of Health Care
25 Planning.

26 (c) In accordance with the laws governing the state civil
27 service, the commissioner shall employ and, with the approval of
28 the Department of Finance, fix the compensation of personnel as
29 necessary to properly discharge the duties imposed upon the
30 commissioner by law, including, but not limited to, a deputy
31 commissioner, a public information officer, a chief enforcement
32 counsel, a Director of the Health Care Fund, a chief medical
33 officer, a consumer advocate, a Director of the Office of Health
34 Care Planning and legal counsel in any action brought by or
35 against the commissioner under or pursuant to any provision of
36 any law under the commissioner's jurisdiction, or in which the
37 commissioner joins or intervenes as to a matter within the
38 commissioner's jurisdiction, as a friend of the court or otherwise,
39 and stenographic reporters to take and transcribe the testimony in
40 any formal hearing or investigation before the commissioner or

1 before a person authorized by the commissioner. The personnel of
2 the agency shall perform duties as assigned to them by the
3 commissioner. The commissioner shall designate certain
4 employees by rule or order that are to take and subscribe to the
5 constitutional oath of office within 15 days after their
6 appointments, and to file that oath with the Secretary of State. The
7 commissioner shall also designate those employees that are to be
8 subject to Title 9 (commencing with Section 81000) of the
9 Government Code.

10 (d) The commissioner shall adopt a seal bearing the inscription:
11 “Commissioner, Health Care Agency, State of California.” The
12 seal shall be affixed to or imprinted on all orders and certificates
13 issued by him or her and other instruments as he or she directs. All
14 courts shall take judicial notice of this seal.

15 (e) The administration of the agency shall be supported from
16 the Health Care Fund created pursuant to Section 140200.

17 (f) The commissioner, as a general rule, shall publish or make
18 available for public inspection any information filed with or
19 obtained by the agency, unless the commissioner finds that this
20 availability or publication is contrary to law. No provision of this
21 division authorizes the commissioner or any of the
22 commissioner’s assistants, clerks, or deputies to disclose any
23 information withheld from public inspection except among
24 themselves or when necessary or appropriate in a proceeding or
25 investigation under this division or to other federal or state
26 regulatory agencies. No provision of this division either creates or
27 derogates from any privilege that exists at common law or
28 otherwise when documentary or other evidence is sought under a
29 subpoena directed to the commissioner or any of his or her
30 assistants, clerks, or deputies.

31 (g) It is unlawful for the commissioner or any of his or her
32 assistants, clerks, or deputies to use for personal benefit any
33 information that is filed with or obtained by the commissioner and
34 that is not then generally available to the public.

35 (h) The commissioner, in pursuit of his or her duties, shall have
36 unlimited access to all nonconfidential and all nonprivileged
37 documents in the custody and control of the agency.

38 (i) The Attorney General shall render to the commissioner
39 opinions upon all questions of law, relating to the construction or
40 interpretation of any law under the commissioner’s jurisdiction or



1 arising in the administration thereof, that may be submitted to the
2 Attorney General by the commissioner and upon the
3 commissioner's request shall act as the attorney for the
4 commissioner in actions and proceedings brought by or against the
5 commissioner or under or pursuant to any provision of any law
6 under the commissioner's jurisdiction.

7 140102. (a) The commissioner shall do all of the following:

8 (1) Establish as part of the administration of the agency all of
9 the following:

10 (A) A Health Policy Board, pursuant to Section 140103.

11 (B) An Office of Consumer Advocacy, pursuant to Section
12 140104.

13 (C) An Office of Health Care Planning, pursuant to Section
14 140601.

15 (D) An Office of Health Care Quality, pursuant to Section
16 140602.

17 (E) A Health Care Fund, pursuant to Section 140200.

18 (2) Implement statutory eligibility standards.

19 (3) Establish an enrollment system that will ensure that all
20 eligible California residents, including those who travel
21 frequently, those who cannot read, and those who do not speak
22 English are aware of their right to health care, and are formally
23 enrolled.

24 (4) Establish a comprehensive budget that ensures adequate
25 funding to meet the health care needs of the population.

26 (5) Establish standards and criteria for allocation of operating
27 funds and funds from the Health Care Fund as described in Chapter
28 3 (commencing with Section 140200).

29 (6) Develop separate formulae for budget allocations and
30 review the formulae annually to ensure that they address
31 disparities in service availability and in health care outcomes and
32 for sufficiency of rates, fees and prices.

33 (7) Negotiate for or set, rates, fees and prices involving any
34 aspect of the health care system, and establish procedures thereto.

35 (8) Utilize the purchasing power of the state to negotiate price
36 discounts for prescription drug and durable and nondurable
37 medical equipment used by the California Health Care System.

38 (9) Ensure that use of state purchasing power achieves the
39 lowest possible prices for the California Health Care System.

- 1 (10) Ensure that price discounts achieved for the system
- 2 formularies are available to all California residents, health care
- 3 providers, wholesalers and retailers.
- 4 (11) Annually establish statewide health care goals for capital
- 5 expenditures established pursuant to Section 140210.
- 6 (12) Ensure a smooth transition to state oversight of capital
- 7 health care planning.
- 8 (13) Annually assess projected revenues and expenditures for
- 9 sufficiency pursuant to Chapter 3 (commencing with Section
- 10 140200).
- 11 (14) Establish or ensure the establishment of an electronic
- 12 claims and payments system for the health care system.
- 13 (15) Ensure the delivery of high quality care to the population,
- 14 pursuant to Chapter 6 (commencing with Section 140600).
- 15 (16) Determine health care system goals and priorities.
- 16 (17) Establish evidence-based standards of care for the health
- 17 care system and ensure a smooth transition to delivery of care
- 18 under statewide standards.
- 19 (18) Adopt a benefits package for consumers. The benefits
- 20 package shall meet or exceed the minimums required by law.
- 21 (19) Establish an evidence-based system formulary for all
- 22 prescription drugs and durable and nondurable medical equipment
- 23 used by the California Health Care System.
- 24 (20) Meet regularly with the chief medical officer, the
- 25 consumer advocate and the Director of Health Care Planning to
- 26 review the impact of the agency and its policies on the health of the
- 27 population and on satisfaction with the health care system.
- 28 (21) Implement policies to ensure that all Californians receive
- 29 culturally and linguistically sensitive care, pursuant to paragraph
- 30 (9) of subdivision (a) of Section 140601 and develop mechanisms
- 31 and incentives to achieve this purpose.
- 32 (22) Establish a Technology Advisory Committee, with the
- 33 advice of the chief medical officer and the director of health
- 34 planning, that will evaluate the cost and effectiveness of new
- 35 medical technology.
- 36 (23) Develop methods, with the advice of the chief medical
- 37 officer, to monitor the quality of care provided to Californians and
- 38 to make needed improvements.
- 39 (24) Implement, to the extent permitted by federal law,
- 40 standardized claims and reporting methods.



1 (25) Procure funds, including loans, lease or purchase of
2 insurance for the system, its employees and agents.

3 (26) Collaborate with state and local authorities to plan for
4 needed earthquake retrofits in a manner that does not disrupt
5 patient care.

6 (b) The commissioner shall report annually to the Legislature
7 and the Governor, on or before October, and at other times
8 pursuant to this section, on the performance of the health care
9 system, its fiscal condition and need for rate adjustments,
10 consumer copayments or consumer deductible payments,
11 recommendations for statutory changes, receipt of payments ~~from~~
12 *from* the federal government, whether current year goals and
13 priorities are met, future goals and priorities, and major new
14 technology or ~~prescriptions~~ *prescription* drugs of other
15 circumstances that may affect the cost of health care.

16 140103. (a) The commissioner shall establish a Health
17 Policy Board and shall be president of the board. The board shall
18 consist of the following members:

19 (1) The commissioner.

20 (2) The deputy commissioner.

21 (3) The Secretary of the Health and Welfare Agency.

22 (4) The Director of the Health Care Fund.

23 (5) The consumer advocate.

24 (6) The chief medical officer.

25 (7) The Director of Health Care Planning.

26 (8) Four physicians all of whom shall be board certified in their
27 field. The Senate Committee on Rules and the Governor shall each
28 appoint one member. The Speaker of the Assembly shall appoint
29 two of these members.

30 (9) One registered nurse, to be appointed by the Governor.

31 (10) One licensed vocational nurse, to be appointed by the
32 Senate Committee on Rules.

33 (11) One licensed allied health practitioner, to be appointed by
34 the Speaker of the Assembly.

35 (12) One mental health care provider, to be appointed by the
36 Senate Committee on Rules.

37 (13) One dentist, to be appointed by the Governor.

38 (14) One representative of private hospitals, to be appointed by
39 the Senate Committee on Rules.

1 (15) One representative of public hospitals, to be appointed by
2 the Governor.

3 (16) Four consumers of health care. The Governor shall
4 appoint two of these members, one of whom shall be a member of
5 the disability community. The Senate Committee on Rules shall
6 appoint a member who is 65 years of age or older. The Speaker of
7 the Assembly shall appoint the fourth member.

8 (17) One representative of organized labor, to be appointed by
9 the Speaker of the Assembly.

10 (18) One representative of essential community providers, to
11 be appointed by the Senate Committee on Rules.

12 (19) One union member, to be appointed by the Senate
13 Committee on Rules.

14 (20) One representative of small business, to be appointed by
15 the Governor.

16 (21) One representative of large business, to be appointed by
17 the Speaker of the Assembly.

18 (22) One pharmacist, to be appointed by the Speaker of the
19 Assembly.

20 (b) In making appointments pursuant to this section, the
21 Governor, the Senate Committee on Rules, and the Speaker of the
22 Assembly shall make good faith efforts to assure that their
23 appointments, as a whole, reflect, to the greatest extent feasible,
24 the social and geographic diversity of the state.

25 (c) Any member appointed by the Governor, the Senate
26 Committee on Rules, or the Speaker of the Assembly shall serve
27 for a four-year term. These members may be reappointed for
28 succeeding four-year terms.

29 (d) Vacancies that occur shall be filled within 30 days after the
30 occurrence of the vacancy, and shall be filled in the same manner
31 in which the vacating member was selected or appointed. The
32 commissioner shall notify the appropriate appointing authority of
33 any expected vacancies on the board.

34 (e) Members of the board shall serve without compensation,
35 but shall be reimbursed for actual and necessary expenses incurred
36 in the performance of their duties to the extent that reimbursement
37 for those expenses is not otherwise provided or payable by another
38 public agency or agencies, and shall receive _____ dollars
39 (\$_____) for each full day of attending meetings of the board. For
40 purposes of this section, “full day of attending a meeting” means



1 presence at, and participation in, not less than 75 percent of the
2 total meeting time of the board during any particular 24-hour
3 period.

4 (f) The board shall meet at least six times a year in a place
5 convenient to the public. All meetings of the board shall be open
6 to the public.

7 (g) A majority of the membership of the board shall constitute
8 a quorum. Any action taken by the board under this division shall
9 require a quorum.

10 (h) The Health Policy Board shall do all of the following:

11 (1) Establish policy on medical issues, population-based public
12 health issues, research priorities, scope of services, expanding
13 access to care, and evaluation of the performance of the system.

14 (2) Evaluate proposals from the chief medical officer and the
15 Director of Health Care Planning for innovative approaches to
16 health promotion, disease and injury prevention, health education
17 and research, and health care delivery.

18 (3) Establish standards and criteria by which requests by health
19 facilities for capital improvements shall be evaluated.

20 (i) It is unlawful for the board or any of its assistants, clerks, or
21 deputies to use for personal benefit any information that is filed
22 with or obtained by the board and that is not then generally
23 available to the public.

24 (j) No member of the board shall make, participate in making,
25 or in any way attempt to use his or her official position to influence
26 a governmental decision in which he or she knows or has reason
27 to know that he or she, or a family member or a business partner
28 or colleague has a financial interest.

29 (k) Members of the board shall be subject to Title 9
30 (commencing with Section 81000) of the Government Code.

31 140104. (a) There is within the agency an Office of
32 Consumer Advocacy to represent the interests of the consumers of
33 health care. The goal of the office shall be to help residents of the
34 state secure the health care services and benefits to which they are
35 entitled under the laws administered by the agency and to advocate
36 on behalf of and represent the interests of consumers in
37 governance bodies created by this division and in other forums.

38 (b) The office shall be headed by a consumer advocate
39 appointed by the commissioner.

1 (c) The consumer advocate shall establish an office in the City
2 of Sacramento and other offices throughout the state that shall
3 provide convenient access to residents.

4 (d) The duties of the consumer advocate shall be determined by
5 the commissioner, and shall include, but not be limited to, all of the
6 following:

7 (1) In collaboration with the chief medical officer and the
8 California Health System Counsel, developing standards and
9 procedures for resolving disputes with the agency.

10 (2) Developing educational and informational guides for
11 consumers describing their rights and responsibilities, and
12 informing them about effective ways to exercise their rights to
13 secure health care services. The guides shall be easy to read and
14 understand, available in English and other languages, and shall be
15 made available to the public by the agency, including access on the
16 agency's Internet Web site and through public outreach and
17 educational programs.

18 (3) Establishing a toll-free telephone number to receive
19 complaints regarding the agency and its services. The hearing and
20 speech impaired may use the California Relay Service's toll-free
21 telephone numbers to contact the Office of Consumer Advocacy.
22 The agency's Internet Web site shall have complaint forms and
23 instructions online.

24 (4) Examining complaints and suggestions from the public.

25 (5) Recommending to the commissioner changes that improve
26 quality of care and patient satisfaction.

27 (6) Examining the extent to which individual health facilities
28 meet the needs of the community in which they are located.

29 (7) Receiving, investigating, and responding to complaints
30 from any source about any aspect of the system, referring the
31 results of investigations to the appropriate professional provider or
32 facility licensing boards or law enforcement agencies, as
33 appropriate.

34 (8) Publishing an annual report to the public and the
35 Legislature containing a statewide evaluation of the agency from
36 the consumer perspective.

37 (9) Serving on the Health Policy Board and participating in the
38 Partnerships for Health that educate the public, health care
39 providers and health care workforce on health care issues.



1 (10) Holding public hearings, at least annually, throughout the
2 state concerning complaints and suggestions from the public.

3 (e) The consumer advocate, in pursuit of his or her duties, shall
4 have unlimited access to all nonconfidential and all nonprivileged
5 documents in the custody and control of the agency.

6 (f) Nothing in this division shall prohibit a consumer or class
7 of consumers or the consumer advocate from seeking relief
8 through the judicial system.

9 140106. There is within the Office of the Attorney General an
10 Office of Inspector General for the California Health Care System.
11 The Inspector General shall be appointed by the Governor and
12 subject to Senate confirmation. The Inspector General shall be
13 subject to the direction of the Attorney General.

14 140107. (a) The Inspector General shall have broad powers
15 to investigate, audit and review the financial and business records
16 of individuals, public and private agencies and institutions, and
17 private corporations that provide services or products to the
18 system, the costs of which are reimbursed by the system. The
19 Inspector General shall investigate allegations of misconduct on
20 the part of an employee or appointee of the agency and on the part
21 of any health care provider of services that are reimbursed by the
22 system and shall report any findings of misconduct to the Attorney
23 General. The Inspector General shall investigate patterns of
24 medical practice that may indicate fraud and abuse related to over
25 or under utilization or other inappropriate utilization of medical
26 products and services.

27 (b) The Inspector General shall arrange for the collection and
28 analysis of data needed to investigate the inappropriate utilization
29 of these products and services. The Inspector General shall
30 conduct additional reviews or investigations of financial and
31 business records when requested by the Governor or by any
32 Member of the Legislature and shall report findings of the review
33 or investigation to the Governor and the Legislature.

34 (c) The Inspector General shall annually report
35 recommendations for improvements to the system or the agency
36 to the Governor and the Legislature.

37 140108. The provisions of the Insurance Fraud Prevention
38 Act (Chapter 12 (commencing with Section 1871), Part 2,
39 Division 1, Insurance Code), and the provisions of Article 6
40 (commencing with Section 650) of Chapter 1 of Division 2 of the

1 Business and Professions Code, shall be applicable to health care
2 providers who receive payments for services through the system
3 under this division.

4 140109. Nothing contained in this division is intended to
5 repeal any legislation or regulation governing the professional
6 conduct of any person licensed by the State of California or any
7 legislation governing the licensure of any facility licensed by the
8 State of California. All federal legislation and regulations
9 governing referral fees and fee-splitting, including, but not limited
10 to, Sections 1320a-7b and 1395nn of Title 42 of the United States
11 Code shall be applicable to all health care providers of services
12 reimbursed under this division, whether or not the health care
13 provider is paid with funds coming from the federal government.

14 140110. (a) The health care system shall be operational no
15 later than January 1, 2006.

16 (b) The commissioner shall appoint a transition advisory group
17 to assist with the transition to the system. The transition advisory
18 group shall include, but not be limited to, the following members:

- 19 (1) The commissioner.
- 20 (2) The consumer advocate.
- 21 (3) The chief medical officer.
- 22 (4) The Director of Health Care Planning.
- 23 (5) The Director of the Health Care Fund.
- 24 (6) Experts in health care financing and health care
25 administration.
- 26 (7) Direct care providers.
- 27 (8) Representatives of retirement boards.
- 28 (9) Employer and employee representatives.
- 29 (10) Hospital, essential community provider, and long-term
30 care facility representatives.
- 31 (11) Representatives from state departments and regulatory
32 bodies that shall or may relinquish some or all parts of their
33 delivery of health service to the system.
- 34 (12) Representatives of counties.
- 35 (13) Consumers of health care.

36 (c) The transition advisory group shall advise the
37 commissioner on all aspects of the implementation of this division.

38 (d) The transition advisory group shall make recommendations
39 to the commissioner, the Governor, and the Legislature on how to

1 integrate health care delivery services and responsibilities of the
2 following departments and agencies into the system:

- 3 (1) The State Department of Health Services.
- 4 (2) The Department of Managed Health Care.
- 5 (3) The Department of Aging.
- 6 (4) The Department of Developmental Services.
- 7 (5) The Health and Welfare Data Center.
- 8 (6) The Department of Mental Health.
- 9 (7) The Department of Alcohol and Drugs.
- 10 (8) The Department of Rehabilitation.
- 11 (9) The Emergency Medical Services Authority.
- 12 (10) The Managed Risk Medical Insurance Board.
- 13 (11) The Office of Statewide Health Planning and
14 Development.

15 (e) The transition advisory group shall investigate the
16 feasibility and costs of including the delivery of health care aspects
17 of the following into the system:

- 18 (1) Workers' compensation.
- 19 (2) State disability insurance.
- 20 (3) Long-term care.

21 (f) The transition advisory group shall recommend potential
22 sources of funds for persons who are displaced from jobs in the
23 transition to the new health care system.

24 (g) The transition advisory group shall report its findings to the
25 commissioner, the Governor, and the Legislature. The transition
26 to the system shall not adversely affect publicly funded programs
27 currently providing health care services.

28 (h) The transition shall be funded from a loan from the General
29 Fund and from private sources identified by the commissioner.

31 CHAPTER 3. FUNDING

33 Article 1. General Provisions

35 140200. (a) In order to support the agency effectively in the
36 administration of this division, there is hereby established in the
37 State Treasury the Health Care Fund. The fund shall be
38 administered by a director, appointed by the commissioner.

39 (b) All moneys collected, received, and transferred pursuant to
40 this division shall be transmitted to the State Treasury to be

1 deposited to the credit of the Health Care Fund for the purpose of
2 financing the California Health Care System.

3 (c) All claims for health care services rendered shall be made
4 to the Health Care Fund.

5 (d) All payments made for health care service shall be
6 disbursed from the Health Care Fund.

7 (e) The director shall sit on the Health Policy Board.

8 140201. (a) The Director of the Health Care Fund shall
9 establish the following accounts within the Health Care Fund:

10 (1) A system account to provide for all annual state
11 expenditures for the health care system.

12 (2) A reserve account.

13 (b) During the first five years of the operation of the system, the
14 director shall maintain a reserve account that equals, at minimum,
15 5 percent of the system's budget. After five years of the system's
16 operation, the director, at the request of the commissioner, may
17 reduce the minimum reserve requirement to 3 percent of the
18 system's budget.

19 (c) The Director of the Health Care Fund shall immediately
20 notify the commissioner when annual costs appear to exceed
21 annual revenues. The commissioner shall determine the cause of
22 excessive costs and implement cost control measures.

23 (d) In the event cost control measures are not sufficient to
24 assure adequate funding, the commissioner shall recommend
25 additional measures to the Legislature to assure sufficient funding,
26 pursuant to Section 140216.

27 (e) If, on June 30 of any year, the Budget Act for the fiscal year
28 beginning on July 1 has not been enacted, all moneys in the reserve
29 account of the Health Care Fund shall be used to implement this
30 division until funds are available through the Budget Act.

31 (f) Notwithstanding any other provision of law and without
32 regard to fiscal year, if the annual State Budget is not enacted by
33 June 30 of any fiscal year preceding the fiscal year to which the
34 budget would apply and if the commissioner determines that funds
35 in the reserve account are depleted, the following shall occur:

36 (1) The Controller shall annually transfer from the General
37 Fund, in the form of one or more loans, an amount not to exceed
38 a cumulative total of ____ dollars (\$____) in any fiscal year, to the
39 Health Care Fund for the purpose of making payments to health
40 care providers.



(2) Upon enactment of the annual Budget Act in any fiscal year to which paragraph (1) applies, the Controller shall transfer all expenditures and unexpended funds loaned to the Health Care Fund to the appropriate Budget Act item.

(3) The amount of any loan made pursuant to subdivision (a) for which moneys were expended from the Health Care Fund shall be repaid by debiting the appropriate Budget Act item in accordance with the procedure prescribed by the Department of Finance.

140202. (a) The commissioner shall annually prepare a comprehensive health system budget that includes all expenditures and shall specify a limit on total annual state expenditures.

(1) The commissioner shall limit growth of health care spending in the system budget by reference to the average growth in state gross domestic product across multiple years; population growth; changes in actuarial demographics and other demographic indicators; advances in technology and changes in technology utilization; and to projected future growth rates.

(2) The commissioner shall annually assess projected revenues and expenditures for the next 12 months and for the subsequent four years in anticipation of projected changes in Gross State Product, population growth, technology advances, actuarial assessments, technologic advances, and other factors that impact spending.

(A) When revenue and expenditure trends indicate a possible funding shortfall, the commissioner shall implement cost control measures pursuant to Section 140216.

(B) When revenue and expenditure trends indicate that cost control measures will not be sufficient to meet the shortfall, the commissioner shall notify the Legislature and shall recommend a plan, including a possible increase in the rate of health taxation, to correct the projected shortfall.

(3) Within two years of initiation of system operations, the commissioner shall limit administrative costs to 5 percent, shall annually evaluate methods to reduce administrative costs, and shall report the results of the evaluation to the Legislature.

(b) The health system budget shall include all of the following:

(1) Health care provider budgets for each of the following principal mechanisms of reimbursement:

- 1 (A) Fee-for-service.
- 2 (B) Capitated systems.
- 3 (C) Systems functioning under operating budgets.
- 4 (D) Health facilities functioning under operating budgets.
- 5 (2) Capital investment budget.
- 6 (3) Purchasing budget.
- 7 (4) Research and innovation budget.
- 8 (5) Workforce development budget.
- 9 (c) In establishing budgets the commissioner shall make
- 10 adjustments based on:
 - 11 (1) Health risk of enrollees.
 - 12 (2) Scope of services provided, including primary, secondary,
 - 13 and tertiary care *and services provided by medical teaching*
 - 14 *facilities*.
 - 15 (3) Proposed innovative programs that improve quality,
 - 16 workplace safety, and consumer, health care provider, and
 - 17 employee satisfaction.
 - 18 (4) Costs of providing care for nonmembers.
 - 19 (5) Need to correct health outcome disparities and the unmet
 - 20 needs of previously underinsured or uninsured enrollees.
 - 21 (6) Relative usage of different health care provider types.
 - 22 (7) Anticipated increases in expenditures due to improved
 - 23 access.
 - 24 (8) Projected savings in administrative costs under a single
 - 25 payer system.
 - 26 (9) Projected savings in prescription drugs and durable and
 - 27 nondurable medical equipment under a single buyer.
 - 28 (10) Projected savings due to provision of primary and
 - 29 preventive care to the population under universal coverage.
 - 30 (11) Potential savings from decreases in inappropriate use of
 - 31 emergency rooms.
 - 32 (12) Projected savings from decreases in medical errors under
 - 33 standards of care, mandatory reporting, and health care provider
 - 34 accountability.
 - 35 (13) Appropriate reimbursement incentives to ensure that the
 - 36 health care system has an adequate supply of health care providers.
 - 37 (14) Appropriate reimbursement incentives for the provision
 - 38 of high quality care that improves health, functionality, and quality
 - 39 of life.

1 (15) Appropriate reimbursement incentives for health care
2 providers who deliver services in medically underserved areas.

3 (16) Appropriate reimbursement incentives to promote a
4 sufficient supply of health care providers to meet the health care
5 needs of the population.

6 (17) Appropriate reimbursement incentives to promote an
7 appropriate ratio of generalist to specialist providers, as
8 determined by the commissioner with the advice of the chief
9 medical officer and the director of planning, to meet the health care
10 needs of the population.

11 (18) No incentive may adversely affect the care a patient
12 receives or the care a health care provider recommends.

13 (d) Moneys in the Reserve Account shall not be considered as
14 available revenues for purposes of preparing the system budget.

15 140204. (a) Health care providers licensed or accredited to
16 provide care in California may choose how they wish to be
17 compensated.

18 (b) Health care provider budgets shall be adjusted annually to
19 account for changes in utilization, covered services, and other
20 factors that affect the costs of delivering care.

21 140205. (a) The budget for fee-for-service health care
22 providers shall be divided among categories of licensed health care
23 providers, in order to establish a total annual budget for each
24 category at the rates negotiated or set by the commissioner. Each
25 of these category budgets shall be sufficient to cover all included
26 services anticipated to be required by eligible individuals choosing
27 fee-for-service care.

28 (b) The commissioner shall negotiate fee-for-service
29 reimbursement rates pursuant to Section 140215.2. In the event
30 negotiations are not concluded in a timely manner, the
31 commissioner shall establish reimbursement rates.

32 140206. (a) Operating budgets for health facilities shall
33 include all operating expenses.

34 (b) The commissioner shall negotiate operating budgets.

35 (c) Health facilities that choose to function under a
36 comprehensive operating budget shall provide annual operating
37 budget requests to the commissioner.

38 (d) Essential community providers that select facility operating
39 budgets as their method of reimbursement shall include in their
40 annual operating budget request any ancillary health care or social

1 services which were previously funded through moneys subsumed
2 into the Health Care Fund.

3 140207. (a) The commissioner shall negotiate capitation
4 rates with health care providers choosing this form of
5 reimbursement.

6 (b) Capitation rates shall be sufficient to cover the cost of care
7 for all enrolled individuals.

8 (c) Capitation rates shall be negotiated pursuant to Section
9 140215.

10 140208. (a) Operating budgets for integrated health care
11 systems, including group practices that function as integrated
12 health care systems and provide a full range of health care services,
13 shall include all system operating expenses.

14 (b) Budgets shall include the labor costs of providing care.

15 (c) The commissioner shall negotiate rates for integrated health
16 care systems.

17 (d) Integrated health care systems choosing to function under
18 an operating budget shall annually submit operating budget
19 requests to the commissioner.

20 (e) Essential Community Providers that qualify as integrated
21 health care systems shall include in their annual operating budget
22 request any ancillary health care or social services that were
23 previously funded through moneys subsumed into the Health Care
24 Fund.

25 140209. Health care providers functioning under capitated or
26 operating budgets shall immediately report any projected
27 operating deficits to the commissioner. The commissioner shall
28 determine whether the projected deficits reflect appropriate
29 increases in health care needs, in which case the commissioner
30 shall adjust the budget appropriately. If the commissioner
31 determines that deficits are not justifiable, no adjustment shall be
32 made.

33 140210. (a) The commissioner shall annually determine a
34 capital investment threshold level below which approval for a
35 capital investment shall not be required. However, notice of plans
36 for capital investments falling below the threshold must be
37 provided to the commissioner three months in advance. Capital
38 investments above the threshold require approval of the
39 commissioner prior to initiation.



1 (b) For purposes of determining the cost of a capital
2 investment, the costs of studies, surveys, design plans, and
3 working drawing specifications or other activities essential to
4 planning and execution of capital investment, or capital
5 investment that changes the bed capacity of a facility or adds a new
6 service or license category, shall be included.

7 (c) When a health facility or individual acting on behalf of a
8 facility, or any other purchaser, obtains by lease or comparable
9 arrangement, any facility or part thereof, or any equipment for a
10 facility, it shall be considered to be a capital expenditure for
11 purposes of this section.

12 (d) No health care provider may make a series of capital
13 investments in a single year or over a period of years for the
14 purpose of avoiding the need to seek approval for a capital project.

15 (e) No capital investment may be undertaken using funds from
16 a health care provider operating budget.

17 (f) The cost of mandatory earthquake retrofits to health
18 facilities shall not be the responsibility of the health care system.
19 However, the commissioner and the director of planning shall
20 coordinate retrofitting with other facility capital investments.

21 (g) If a facility makes a capital investment above the specified
22 threshold without prior approval of the commissioner, there shall
23 be no reimbursement from the health care system for services
24 provided in the buildings or with the equipment or from any aspect
25 of an unapproved capital investment.

26 (h) Health care providers may submit requests for approval of
27 a capital project at the time they submit operating or capitated
28 budget requests or at other times determined by the commissioner.

29 (i) Capital investment priorities shall reflect the need to correct
30 health care disparities and the unmet needs of underserved regions
31 and populations.

32 140211. (a) The commissioner shall establish a budget for
33 the purchase of prescription drugs and durable and nondurable
34 medical equipment for the health care system.

35 (b) The commissioner shall use the purchasing power of the
36 state to obtain the lowest possible prices for prescription drugs and
37 durable and nondurable medical equipment and shall make
38 discounted prices available to all California residents, health care
39 providers, wholesalers, and ~~retails~~ *retailers* of these products for
40 use in the California health care system.

1 140212. (a) The commissioner shall establish a budget to
2 support research and innovation that has been recommended by
3 the chief medical officer, the director of planning, and the
4 consumer advocate.

5 (b) The research and innovation budget shall support the goals
6 and priorities of the health care system.

7 (c) Research and innovation includes, but is not limited to,
8 methods of improving administrative efficiency, the quality of
9 care delivered to Californians, communication among health care
10 providers, and the education of patients.

11 40213. (a) The commissioner shall establish a budget to
12 support the development and training of a health system workforce
13 that is sufficient to meet the health care needs of the population.

14 (b) The commissioner shall give special consideration for
15 training to workers who have been displaced from employment
16 due to the inception of the system.

17 140214. (a) Reimbursement methods shall include
18 fee-for-service and capitation.

19 (b) Reimbursement rates shall be established prior to initiation
20 of health system operations.

21 (c) An electronic claims and payment system shall be
22 operational prior to initiation of health system operations.

23 (d) No health care provider may charge or receive payments for
24 covered services except those provided by the health care system.

25 (e) Licensed health care providers who deliver services not
26 covered by this division may establish rates for, and charge
27 patients for, those services.

28 (f) The commissioner shall establish a system of health care
29 provider reimbursement that ensures:

30 (1) Timely payments through a structure that is efficient to
31 administer and that eliminates unnecessary administrative costs.

32 (2) Reimbursement to health care providers for all covered
33 health care services they provide, including care provided to
34 persons who are subsequently determined to be ineligible for the
35 California health care system.

36 (3) Receipt of payment by health care providers within ____
37 business days of receipt of a claim by the Health Care Fund that
38 has been properly filed according to procedures established by the
39 commissioner and accrual of interest at a rate of ____ percent
40 compounded daily for properly filed claims for covered services

1 from an eligible claimant paid later than ____ business days of
2 receipt by the Health *Care* Fund.

3 (4) Actuarially sound reimbursement rates.

4 (5) Specification in reimbursement contracts of health care
5 provider payment rates, and the actuarial basis for computation of
6 those rates.

7 140215. Reimbursement rates for health care providers
8 employed in integrated health care systems, essential community
9 providers and group medical practices that function as integrated
10 health care systems shall be determined by negotiations between
11 health care providers and their employers.

12 140215.1. (a) Reimbursement rates for health care providers
13 choosing fee-for-service reimbursements shall be negotiated on a
14 class basis with the commissioner. Representatives of health care
15 providers shall be democratically selected by the represented
16 health care providers or health care provider networks.

17 (b) It is the intent of this division that the negotiations provided
18 for be conducted in a manner that is consistent with the state action
19 immunity doctrine, which establishes immunity from federal and
20 state antitrust laws for conduct taken or supervised by a state.

21 (c) A contract negotiated pursuant to this section shall be
22 subject to a confirmation process.

23 (d) Upon negotiation of a contract, the parties, or upon
24 successful mediation, the mediator, or if the parties agree to
25 arbitration, the arbitrator, shall file a copy of the contract with the
26 Office of the Attorney General and a statement of the reasons and
27 submitted evidence for review. After an independent review, the
28 Attorney General shall confirm, modify, or vacate the contract.

29 140216. (a) The commissioner shall implement cost controls
30 pursuant to Section 140201.

31 (b) No cost control measure shall limit access to care that is
32 needed on an emergency basis or that is determined by a patient's
33 health care provider to be medically appropriate for a patient's
34 condition.

35 (c) Mandatory cost control measures shall include, but not be
36 limited to, some or all of the following:

37 (1) Postponement of introduction of new benefits or benefit
38 improvements.

39 (2) Postponement of new capital investment.

(3) Adjustment of health care provider budgets to correct for inappropriate health care provider utilization.

(4) Limitations on health care provider reimbursement above a specified amount of aggregate billing.

(5) Deferred funding of the Reserve Account.

(6) Establishment of a limit on aggregate reimbursements to manufacturers of pharmaceutical manufacturers and durable and nondurable medical equipment.

(7) Imposition of copayments or deductible payments pursuant to provisions of Section 140504.

(8) Imposition of an eligibility waiting period in the event of substantial influx of individuals into the state for the purpose of obtaining health care through the system.

Article 2. Revenues

140217. It is the intent of the Legislature to dedicate revenue from the following sources for deposit in the Health Care Fund:

~~(a) A personal income tax for health care on earned and unearned income.~~

~~(b) An employer payroll tax.~~

~~(c) A self-employed business tax.~~

(a) A payroll tax to be paid by employers and employees.

(b) A self-employed earnings tax.

(c) A tax on nonwage income.

Article 3. Governmental Payments

140218. (a) (1) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current federal payments to the state for health care be paid directly to the California Health Care System, which shall then assume responsibility for all benefits and services previously paid for by the federal government with those funds.

(2) In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the federal government a contribution for health care services in California that shall not decrease in relation to the contribution to other states as a result of the waivers, exemptions, agreements, or legislation.

1 (b) (1) The commissioner shall seek all necessary waivers,
2 exemptions, agreements, or legislation, so that all current state
3 payments for health care shall be paid directly to the system, which
4 shall then assume responsibility for all benefits and services
5 previously paid for by state government with those funds.

6 (2) In obtaining the waivers, exemptions, agreements, or
7 legislation, the commissioner shall seek from the Legislature a
8 contribution for health care services that shall not decrease in
9 relation to state government expenditures for health care services
10 in the year that this division was enacted, except that it may be
11 corrected for change in state gross domestic product, the size and
12 age of population, and the number of residents living below the
13 federal poverty level.

14 (c) The commissioner shall establish formulas for equitable
15 contributions to the health care system from all California counties
16 and other local government agencies.

17 (d) The commissioner shall seek all necessary waivers,
18 exemptions, agreements, or legislation, so that all county or other
19 local government agency payments shall be paid directly to the
20 health care system.

21 140219. The system's responsibility for providing care shall
22 be secondary to existing federal, state, or local governmental
23 programs for health care services to the extent that funding for
24 these programs are not transferred to the Health Care Fund or that
25 the transfer is delayed beyond the date on which initial benefits are
26 provided under the system.

27 140220. In order to minimize the administrative burden of
28 maintaining eligibility records for programs transferred to the
29 system, the commissioner shall strive to reach an agreement with
30 federal, state, and local governments in which their contributions
31 to the Health Care Fund shall be fixed to the rate of change of the
32 state gross domestic product, the size and age of population, and
33 the number of residents living below the federal poverty level.

34 140221. If, and to the extent that, federal law and regulations
35 ~~allows~~ allow the transfer of Medi-Cal funding to the system, the
36 commissioner shall pay from the Health Care Fund all premiums,
37 deductible payments, and coinsurance for qualified Medicare
38 beneficiaries who are receiving benefits pursuant to Chapter 3
39 (commencing with Section 12000) of Part 3 of Division 9 of the
40 Welfare and Institutions Code.

1 140222. In the event and to the extent that the commissioner
2 obtains authorization to incorporate Medicare revenues into the
3 Health Care Fund, Medicare Part B payments that previously were
4 made by individuals ~~or the commissioner~~ shall be paid by the
5 system for all individuals eligible for both the system and the
6 Medicare program.

7
8 Article 4. Federal Preemption
9

10 140300. (a) The commissioner shall pursue all reasonable
11 means to secure a repeal or a waiver of any provision of federal law
12 that preempts any provision of this division.

13 (b) In the event that a repeal or a waiver cannot be secured, the
14 commissioner shall exercise his or her powers to promulgate rules
15 and regulations, or seek conforming state legislation, consistent
16 with federal law, in an effort to best fulfill the purposes of this
17 division.

18 140301. (a) To the extent permitted by federal law, an
19 employee entitled to health or related benefits under a contract or
20 plan that, under federal law, preempts provisions of this division,
21 shall first seek benefits under that contract or plan before receiving
22 benefits from the system under this division.

23 (b) No benefits shall be denied under the system created by this
24 division unless the employee has failed to take reasonable steps to
25 secure like benefits from the contract or plan, if those benefits are
26 available.

27 (c) Nothing in this section shall preclude a person from
28 receiving benefits from the system under this division that are
29 superior to benefits available to the person under an existing
30 contract or plan.

31 (d) Nothing in this division is intended, nor shall this division
32 be construed, to discourage recourse to contracts or plans that are
33 protected by federal law.

34 (e) To the extent permitted by federal law, a health care
35 provider shall first seek payment from the contract or plan, before
36 submitting bills to the health care system.
37

Article 5. Subrogation

140302. (a) It is the intent of this division to establish a single public payer for all health care in the State of California. However, until such time as the role of all other payers for health care have been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, health care service plan, or other collateral source available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

(b) As used in this article, collateral source includes all of the following:

(1) Insurance policies written by insurers, including the medical components of automobile, homeowners, and other forms of insurance.

(2) Health care service plans and pension plans.

(3) Employers.

(4) Employee benefit contracts.

(5) Government benefit programs.

(6) A judgment for damages for personal injury.

(7) Any third party who is or may be liable to an individual for health care services or costs.

(c) “Collateral source” does not include either of the following:

(1) A contract or plan that is subject to federal preemption.

(2) Any governmental unit, agency, or service, to the extent that subrogation is prohibited by law. An entity described in subdivision (b) is not excluded from the obligations imposed by this article by virtue of a contract or relationship with a governmental unit, agency, or service.

(d) The commissioner shall attempt to negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources in California into the health care system.

140303. Whenever an individual receives health care services under the system and he or she is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, he or she shall notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant

1 information. The health care provider shall forward this
2 information to the commissioner. The individual entitled to
3 coverage, reimbursement, indemnity, or other compensation from
4 a collateral source shall provide additional information as
5 requested by the commissioner.

6 140304. (a) The system shall seek reimbursement from the
7 collateral source for services provided to the individual, and may
8 institute appropriate action, including suit, to recover the
9 reimbursement. Upon demand, the collateral source shall pay to
10 the Health Care Fund the sums it would have paid or expended on
11 behalf of the individual for the health care services provided by the
12 system.

13 (b) In addition to any other right to recovery provided in this
14 article, the commissioner shall have the same right to recover the
15 reasonable value of benefits from a collateral source as provided
16 to the Director of Health Services by Article 3.5 (commencing
17 with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of the
18 Welfare and Institutions Code, in the manner so provided.

19 140305. (a) If a collateral source is exempt from subrogation
20 or the obligation to reimburse the system as provided in this article,
21 the commissioner may require that an individual who is entitled to
22 medical services from the source first seek those services from that
23 source before seeking those services from the system.

24 (b) To the extent permitted by federal law, contractual retiree
25 health benefits provided by employers shall be subject to the same
26 subrogation as other contracts, allowing the health care system to
27 recover the cost of services provided to individuals covered by the
28 retiree benefits, unless and until arrangements are made to transfer
29 the revenues of the benefits directly to the health care system.

30 140306. (a) Default, underpayment, or late payment of any
31 tax or other obligation imposed by this division shall result in the
32 remedies and penalties provided by law, except as provided in this
33 section.

34 (b) Eligibility for benefits under Chapter 4 (commencing with
35 Section 140400) shall not be impaired by any default,
36 underpayment, or late payment of any tax or other obligation
37 imposed by this chapter.

38 ~~140307. The agency and the commissioner shall be exempt~~
39 ~~from the regulatory oversight and review procedures empowered~~
40 ~~to the Office of Administrative Law pursuant to Chapter 3.5~~

1 ~~(commencing with Section 11340) of Division 3 of Title 2 of the~~
2 ~~Government Code. Actions taken by the agency, including, but not~~
3 ~~limited to, the negotiating or setting of rates, fees, or prices, and~~
4 ~~the promulgation of any and all regulations, shall be exempt from~~
5 ~~any review by the Office of Administrative Law, except for~~
6 ~~Sections 11344.1, 11344.2, 11344.3, and 11344.6 of the~~
7 ~~Government Code, addressing the publication of regulations.~~

8 *140307. The California Health Care Agency shall adopt*
9 *regulations to implement the provisions of this division. The*
10 *regulations may initially be adopted as emergency regulations in*
11 *accordance with the Administrative Procedure Act (Chapter 3.5*
12 *(commencing with Section 11340) of Part 1 of Division 3 of Title*
13 *2 of the Government Code), but those emergency regulations shall*
14 *be in effect only from the effective date of this division until the*
15 *conclusion of the transition period.*

16 17 CHAPTER 4. ELIGIBILITY 18

19 140400. All California residents shall be eligible for the
20 California Health Care System. Residency shall be based upon
21 physical presence in the state with the intent to reside. The
22 commissioner shall establish standards and a simplified procedure
23 to demonstrate proof of residency.

24 140401. The commissioner shall establish a procedure to
25 enroll eligible residents and provide each eligible individual with
26 identification that can be used by health care providers to
27 determine eligibility for services.

28 140402. (a) *It is the intent of the Legislature for the*
29 *California Health Care System to provide health care coverage to*
30 *California residents who are temporarily out of the state. The*
31 *commissioner shall determine eligibility standards for residents*
32 *temporarily out of state for longer than 90 days who intend to*
33 *return and reside in California and for nonresidents temporarily*
34 *employed in California.*

35 (b) Coverage for emergency care obtained out of state shall be
36 at prevailing local rates. Coverage for nonemergency care
37 obtained out of state shall be according to rates and conditions
38 established by the commissioner. The commissioner may require
39 that a resident be transported back to California when prolonged
40 treatment of an emergency condition is necessary.

1 140403. Visitors to California shall be billed for all services
2 received under the system. The commissioner may establish
3 intergovernmental arrangements with other states and countries to
4 provide reciprocal coverage for temporary visitors.

5 140404. All persons eligible for health benefits from
6 California employers but who are working in another jurisdiction
7 shall be eligible for health benefits under this division providing
8 that they make payments equivalent to the payments they would
9 be required to make if they were residing in California.

10 140405. Unmarried, unemancipated minors shall be deemed
11 to have the residency of their parent or guardian. If a minor's
12 parents are deceased and a legal guardian has not been appointed,
13 or if a minor has been emancipated by court order, the minor may
14 establish his or her own residency.

15 140406. (a) An individual shall be presumed to be eligible if
16 he or she arrives at a health facility and is unconscious, comatose,
17 or otherwise unable, because of his or her physical or mental
18 condition, to document eligibility or to act in his or her own behalf,
19 or if the patient is a minor, the patient shall be presumed to be
20 eligible, and the health facility shall provide care as if the patient
21 were eligible.

22 (b) Any individual shall be presumed to be eligible when
23 brought to a health facility pursuant to any provision of Section
24 5150 of the Welfare and Institutions Code.

25 (c) Any individual involuntarily committed to an acute
26 psychiatric facility or to a hospital with psychiatric beds pursuant
27 to any provision of Section 5150 of the Welfare and Institutions
28 Code, providing for involuntary commitment, shall be presumed
29 eligible.

30 (d) All health facilities subject to state and federal provisions
31 governing emergency medical treatment shall continue to comply
32 with those provisions.

33 CHAPTER 5. BENEFITS

34
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36 140500. Any eligible individual may choose to receive
37 services under the California Health Care System from any willing
38 professional health care provider participating in the system. No
39 health care provider may refuse to care for a patient solely on any
40 basis that is specified in the prohibition of employment

1 discrimination contained in the Fair Employment and Housing Act
2 beginning with Section 12940 of the Government Code.

3 140501. Covered benefits in this chapter shall include all
4 medical care determined to be medically appropriate by the
5 consumer's health care provider, but are subject to limitations set
6 forth in ~~Section~~ Sections 140503 and 140504. Covered benefits
7 include, but are not limited to, all of the following:

8 (a) Inpatient and outpatient health facility services.

9 (b) Inpatient and outpatient professional health care provider
10 services by licensed health care professionals.

11 (c) Diagnostic imaging, laboratory services, and other
12 diagnostic and evaluative services.

13 (d) Durable medical equipment, appliances, and assistive
14 technology, including prosthetics, eyeglasses, and hearing aids
15 and their repair.

16 (e) Rehabilitative care.

17 (f) Emergency transportation and necessary transportation for
18 health care services for disabled and indigent persons.

19 (g) Language interpretation and translation for health care
20 services, including sign language for those unable to speak, or
21 hear, or who are language impaired, and braille translation or other
22 services for those with no or low vision.

23 (h) Child and adult immunizations and preventive care.

24 (i) Health education.

25 (j) Hospice care.

26 (k) Home health care.

27 (l) Prescription drugs that are listed on the system formulary.
28 Nonformulary prescription drugs may be included where
29 standards and criteria established by the commissioner are met.

30 (m) Mental and behavioral health care.

31 (n) Dental care.

32 (o) Podiatric care.

33 (p) Chiropractic care.

34 (q) Acupuncture.

35 (r) Blood and blood products.

36 (s) Emergency care services.

37 (t) Vision care.

38 (u) Adult day care.

1 (v) Case management and coordination to ensure services
2 necessary to enable a person to remain safely in the least restrictive
3 setting.

4 (w) Substance abuse treatment.

5 (x) Care of up to 100 days in a skilled nursing facility following
6 hospitalization.

7 (y) Dialysis.

8 (z) Benefits offered by a bona fide church, sect, denomination,
9 or organization whose principles include healing entirely by
10 prayer or spiritual means provided by a duly authorized and
11 accredited practitioner or nurse of that bona fide church, sect,
12 denomination, or organization.

13 140502. The commissioner may expand benefits beyond the
14 minimum benefits described in this chapter when expansion meets
15 the intent of this division and when there are sufficient funds to
16 cover the expansion.

17 140503. The following health care services shall be excluded
18 from coverage by the system:

19 (a) Health care services determined to have no medical
20 indication by the commissioner and the chief medical officer.

21 (b) Surgery, dermatology, orthodontia, prescription drugs, and
22 other procedures primarily for cosmetic purposes, unless required
23 to correct a congenital defect, restore or correct a part of the body
24 that has been altered as a result of injury, disease, or surgery, or
25 determined to be medically necessary by a qualified, licensed
26 health care provider in the system.

27 (c) Private rooms in inpatient health facilities *where*
28 *appropriate nonprivate rooms are available*, unless determined to
29 be medically necessary by a qualified, licensed health care
30 provider in the system.

31 (d) Services of a professional health care provider or facility
32 that is not licensed or accredited by the state *except for approved*
33 *services provided to a California resident who is temporarily out*
34 *of the state*.

35 140504. (a) The commissioner shall institute no deductible
36 payments or copayments other than for specialist visits that are
37 unreferred by the primary care provider pursuant to subdivision
38 (g) of Section 140600 during the initial two years of the systems
39 operation. The commissioner and the Health Policy Board shall
40 review this policy annually, beginning in the third year of

1 operation, and determine whether deductible payments or
2 copayments should be established.

3 (b) Patients shall incur a copayment charge for unreferred
4 specialist visits, the amount of which shall be established by the
5 commissioner.

6 (c) If the commissioner establishes copayments consistent with
7 subdivision (a), they shall be limited to two hundred fifty dollars
8 (\$250) per person per year and five hundred dollars (\$500) per
9 family per year. Copayments for unreferred specialist visits shall
10 not be subject to this limit.

11 (d) If the commissioner establishes deductible payments
12 consistent with subdivision (a), they shall be limited to two
13 hundred fifty dollars (\$250) per person per year and five hundred
14 dollars (\$500) per family per year.

15 (e) No copayments or deductible payments may be established
16 for preventive care as determined by a patient's primary care
17 provider.

18 (f) No copayments or deductible payments may be established
19 when prohibited by federal law.

20 (g) The commissioner shall establish standards and procedures
21 for waiving copayments or deductible payments. Waivers of
22 copayments or deductible payments shall not affect the
23 reimbursement of health care providers.

24 (h) Any copayments established pursuant to this section and
25 collected by health care providers shall be transmitted to the
26 Treasurer to be deposited to the credit of the Health Care Fund.

27 (i) Nothing in this division shall be construed to diminish the
28 benefits that an individual has under a collective bargaining
29 agreement.

30 (j) Nothing in this division shall preclude employees from
31 receiving benefits available to them under a collective bargaining
32 agreement or other employee-employer agreement that are
33 superior to benefits under this division.

34 CHAPTER 6. DELIVERY OF CARE

35
36
37 140600. (a) All health care providers licensed or accredited
38 to practice in California may participate in the Health Care
39 System.

1 (b) No health care provider whose license or accreditation is
2 suspended or revoked may be a participating health care provider.

3 (c) If a health care provider is on probation, the licensing or the
4 accrediting agency shall monitor the health care provider in
5 question, pursuant to applicable California law.

6 (d) Health care providers may accept eligible persons for care
7 in the order of time of application and by the health care provider's
8 ability to provide services needed by the applicant.

9 (e) A health care provider shall not refuse to care for a patient
10 solely on any basis that is specified in the prohibition of
11 employment discrimination contained in the Fair Employment
12 and Housing Act (Part 2.8 (commencing with Section 12900),
13 Division 3, Title 2, Government Code).

14 (f) Choice of primary care provider.

15 (1) Persons eligible for health care services under this division
16 may choose a primary care provider.

17 (2) Persons who choose to enroll in an integrated health care
18 system, a group medical practice, or with an essential community
19 provider shall retain membership for at least one year after an
20 initial three-month evaluation period during which time they may
21 withdraw for any reason. Persons who want to withdraw after an
22 initial three-month period may appeal to the consumer advocate
23 who may authorize early disenrollment.

24 (3) Persons needing to change primary care providers because
25 of unanticipated health care needs that their primary care provider
26 cannot meet may change primary care providers at any time.

27 (4) Primary care providers include family physicians,
28 internists, pediatricians, ~~obstetrician/gynecologists~~
29 *obstetricians/gynecologists*, and family nurse practitioners and
30 physician assistants practicing under supervision as defined in
31 California codes.

32 (5) Primary health care providers shall coordinate the care their
33 patients receive.

34 (g) (1) Patients must have a referral from their primary care
35 provider to see a specialist without paying a copayment.

36 (2) Patients will incur a copayment charge for unreferral
37 specialist visits, the amount of which will be established by the
38 commissioner.

39 (3) A referral shall not be required to see a dentist.

1 (4) Referrals shall be based on the medical needs of a patient
2 and on the system standards of care and shall not be restricted
3 solely because of financial considerations.

4 (5) Patients established with a specialist before the act is
5 implemented do not need a referral to continue seeing the
6 specialist.

7 (6) Patients may choose a specialist as a primary care provider
8 if the specialist agrees to serve in that capacity. A specialist who
9 agrees to serve as a primary care provider shall coordinate the care
10 that a patient receives.

11 (7) Emergency health care providers may make referrals to a
12 specialist when a patient is treated in the emergency room or by
13 any health care provider seeing a patient for an emergency
14 condition. No copayments may be charged for these specialist
15 referrals.

16 (8) Specialists receiving requests for appointments from new
17 patients shall be given the ability to determine through the use of
18 a statewide computerized referral registry whether the patient's
19 primary care provider has referred the patient.

20 (9) In cases where a referral is denied by a primary care
21 provider, a patient may appeal the denial to the consumer advocate.

22 (10) During the transition, the commissioner, with the advice
23 of the chief medical officer, shall determine whether there shall be
24 a policy under which patients must have a referral in order to see
25 nonphysician specialists.

26 140601. (a) The Director of the Office of Health Care
27 Planning shall plan for the health care needs of the population. In
28 planning for the health needs of the population the director shall
29 do all the following:

30 (1) Annually develop, in consultation with the chief medical
31 officer and the consumer advocate, a comprehensive and equitable
32 plan to meet the health care needs of the population.

33 (2) Establish performance criteria in measurable terms for the
34 goals and priorities of the health care system established by the
35 commissioner.

36 (3) Identify medically underserved areas and health service
37 shortages and recommend to the commissioner means to assure
38 that all residents have access to needed services.

- 1 (4) Identify disparities in health outcomes and recommend to
2 the commissioner means to eliminate disparities and improve
3 population health.
- 4 (5) Collaborate with the chief medical officer, with state and
5 with local agencies that provide health services and with the
6 consumer advocate in planning for the health needs of the
7 population.
- 8 (6) Develop integrated statewide population-based health care
9 databases to support health care planning. In establishing
10 databases the director shall do all the following:
 - 11 (A) Establish reporting priorities and guidelines.
 - 12 (B) Monitor the effectiveness of reporting and initiate needed
13 improvements.
 - 14 (C) Establish mandatory reporting requirements and penalties
15 for noncompliance.
 - 16 (D) Establish standards and criteria for anonymous reporting
17 of medical errors.
 - 18 (E) Establish standards and criteria to maintain the security of
19 state databases.
- 20 (7) Estimate of the health care workforce required to meet the
21 health needs of the population and develop 5, 10, 15, and 20 year
22 plans to meet those workforce needs.
- 23 (8) Estimate the number and types of health facilities required
24 to meet the health needs of the population and develop 5, 10 and
25 20 year plans to meet those needs.
- 26 (9) Recommend improvements to the commissioner to assure
27 the delivery of culturally and linguistically competent care.
- 28 (10) Establish standards for the delivery of culturally and
29 linguistically competent care. Standards shall include, but shall
30 not be limited to:
 - 31 (A) The State Department of Health Services and the
32 Department of Managed Health Care guidelines for culturally
33 competent and linguistically sensitive care.
 - 34 (B) Medi-Cal Managed Care Division (MMCD) Policy Letters
35 99-01 to 99-04 and MMCD All Plan Letter 99005 by the Cultural
36 and Linguistic.
 - 37 (C) Subchapter 5 of the Civil Rights Act of 1964 (42 U.S.C.
38 Sec. 2000d).
 - 39 (D) The United States Department of Health and Human
40 Services' Office of Civil Rights; Title VI of the Civil Rights Act



1 of 1964; Policy Guidance on Prohibition Against National Origin
2 Discrimination as It Affects Persons with Limited English
3 Proficiency (February 1, 2002).

4 (E) The United States Department of Health and Human
5 Services' Office of Minority Health; National Standards on
6 Culturally and Linguistically Appropriate Services (CLAS) in
7 Health Care—Final Report (December 22, 2000).

8 (11) Plan for system capital health care needs. In planning for
9 system capital needs the director shall do all of the following:

10 (A) Identify capital health care needs on a statewide, regional,
11 and local basis and recommend to the commissioner priorities for
12 annual and for long-term capital investment, including projections
13 for 5, 10 and 20 years.

14 (B) Collaborate with cities and counties to coordinate capital
15 health planning and investment.

16 (C) Collaborate with California health care institutions and
17 integrated health care systems to reconcile their internal capital
18 development needs with those of the health care system.

19 (D) Collaborate with state and local authorities and health care
20 institutions to plan for needed earthquake retrofits.

21 (E) Plan for equitable access for the population to specialized
22 regional centers that perform a high volume of procedures for
23 conditions requiring highly specialized treatments, including
24 emergency and trauma care.

25 (F) Evaluate the effectiveness of statewide capital planning and
26 recommend needed improvements.

27 (12) Recommend to the commissioner means to link state and
28 private research to the goals and priorities of the health care
29 system.

30 (b) The director shall serve on the Health Policy Board.

31 140602. (a) The chief medical officer, as Director of the
32 Office of Health Care Quality, shall support the delivery of high
33 quality care, as defined under this act, and shall promote health
34 care provider and patient satisfaction.

35 (b) The chief medical officer shall serve on the Health Policy
36 Board.

37 140603. The chief medical officer shall recommend annually
38 to the commissioner and the planning director evidence-based
39 standards of care for the health care system. In making

1 recommendations the chief medical officer shall do all of the
2 following:

3 (1) Draw on existing standards established by California
4 institutions and other institutions, such as the Centers for Disease
5 Control, the Agency for Health Care Quality and Research, and
6 others engaged in establishing and evaluating standards of care.

7 (2) Collaborate with California health care institutions and
8 other institutions and with local, state, and federal agencies
9 engaged in establishing and evaluating standards of care.

10 (3) Constitute peer groups of practitioners to review and
11 recommend standards of care in their fields of expertise.

12 (4) Constitute peer groups of practitioners to recommend
13 means to improve care coordination.

14 (5) Consult with all classes of health care providers to
15 determine the best means to implement standards.

16 (6) Collaborate with the consumer advocate and consumers of
17 care to obtain recommendations on standards of care.

18 (7) Identify improvements in computer hardware
19 infrastructure and software needed to support user-friendly
20 dissemination of standards of care to all California health care
21 providers.

22 (8) Identify areas where standards of care have not been
23 established and set priorities for identifying or developing
24 standards.

25 140604. (a) The chief medical officer shall recommend
26 semiannually to the commissioner and the planning director an
27 evidence-based pharmaceutical formulary for the health care
28 system. In recommending the formulary the chief medical officer
29 shall establish a Pharmacy and Therapeutics Committee
30 composed of pharmacy and medical health care providers and
31 representatives of California health care institutions that use
32 system pharmaceutical formularies and other identified experts to
33 do the following:

34 (1) Identify safe and effective pharmaceutical agents for use in
35 California.

36 (2) Draw on existing standards and formularies.

37 (3) Identify experimental drugs and drug treatment protocols
38 for possible inclusion in the formulary.

1 (4) Review formulary standards monthly to ensure that safe
2 and effective drugs are available and that unsafe drugs are removed
3 from use in a timely fashion.

4 (5) Recommend to the commissioner standards and criteria and
5 a process for approval for the use of pharmaceutical agents not
6 included in the system formulary. No standard or criteria shall
7 impose an undue administrative burden on patients, health care
8 providers, pharmacies, or pharmacists and none shall delay care
9 that a patient needs.

10 (b) No person working within the agency or serving as a
11 consultant to the agency may receive any fees or remuneration
12 from a pharmaceutical company.

13 140605. The chief medical officer shall recommend annually
14 to the commissioner an evidence-based durable and nondurable
15 medical equipment formulary for the health care system. In
16 recommending the formulary, the chief medical officer shall
17 follow the general guidelines and processes enumerated in Section
18 140405.

19 140606. (a) The chief medical officer shall recommend
20 annually to the commissioner evidence-based benefits for the
21 health care system and priorities for needed benefit improvements.
22 In making recommendations the chief medical officer shall do all
23 of the following:

24 (1) Identify safe and effective treatments for use in the system.

25 (2) Evaluate and draw on existing benefit packages.

26 (3) Collaborate with health care providers about benefits that
27 meet the needs of their patients.

28 (4) Collaborate with the consumer advocate and with
29 consumers about benefits that meet the needs of patients.

30 (5) Recommend to the commissioner innovative approaches to
31 health promotion, disease and injury prevention, education,
32 research and health care delivery.

33 (6) Identify complementary and alternative modalities that
34 have been shown by the National Institutes of Health to be safe and
35 effective for possible inclusion as a covered benefit.

36 (7) Recommend to the commissioner standards, criteria, and a
37 process for approval of services not included in the system benefit
38 package. No standard or criteria shall impose an undue
39 administrative burden on health care providers or patients and
40 none shall delay the care a patient needs.

1 140607. (a) The commissioner shall develop or ensure the
2 development of a system of electronic medical records for the
3 health care system, with the advice of the chief medical officer and
4 the Director of Health Care Planning.

5 (b) The commissioner shall develop or ensure the development
6 of an electronic referral system, with the advice of the chief
7 medical officer and the Director of Health Care Planning.

8 (c) The commissioner shall establish or ensure the
9 establishment of an electronic claims and payments system for the
10 health care system.

11 (d) Electronic health records, referral, and claims and
12 reimbursement systems shall be accessible to health care providers
13 throughout the state in all practice settings, shall include means to
14 protect patient, health care provider and institution privacy, shall
15 place no undue administrative burden on a health care provider or
16 a patient, and shall not delay care a patient needs.

17 (e) Electronic health records, referrals, claims, and
18 reimbursement systems shall be compatible with all health care
19 institutions in the state and shall accommodate software developed
20 under the auspices of the health care system.

21 140609. (a) The chief medical officer, in collaboration with
22 the planning director, shall recommend, and update as necessary,
23 an appropriate ratio of general medical practitioners to specialty
24 medical practitioners to meet the health needs of the population
25 and the goals of the California Health Care System.

26 (b) The chief medical officer shall recommend to the
27 commissioner financial and nonfinancial incentives and other
28 means to achieve the recommended ratios.

29 (c) The chief medical officer shall monitor the effectiveness of
30 efforts to achieve the desired ratios and recommend needed
31 improvements.

32 140610. (a) The chief medical officer, in collaboration with
33 the consumer advocate and the planning director shall develop a
34 statewide program called “Partnerships For Health” to educate
35 the public, health care providers, and the health care workforce
36 about:

37 (1) Personal maintenance of health.

38 (2) Prevention of disease.

39 (3) Improving communication between patients and health
40 care providers.



1 (4) Improving quality of care.
2 SEC. 2. No reimbursement is required by this act pursuant to
3 Section 6 of Article XIII B of the California Constitution because
4 the only costs that may be incurred by a local agency or school
5 district will be incurred because this act creates a new crime or
6 infraction, eliminates a crime or infraction, or changes the penalty
7 for a crime or infraction, within the meaning of Section 17556 of
8 the Government Code, or changes the definition of a crime within
9 the meaning of Section 6 of Article XIII B of the California
10 Constitution.

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